Background

Transitions from hospital to home can be complicated and risky, especially for individuals with multiple chronic illnesses. Patients frequently report difficulty remembering clinical instructions, confusion over correct use of medications, and uncertainty over their prognosis. In cases where multiple providers are involved, patients often get conflicting instructions from different providers.

A study published in April 2009 in the New England Journal of Medicine found that almost one-third of Medicare beneficiaries studied who were discharged from a hospital were re-hospitalized within 90 days. Additionally, one-half of the individuals re-hospitalized had not visited a physician since their discharge, indicating a lack of follow-up care. The study also estimated that Medicare spent $17.4 billion in 2004 on unplanned re-hospitalizations.

Solution

Legislation that Congressman Blumenauer has introduced, the bipartisan Medicare Transitional Care Act, supports and coordinates care for beneficiaries as they move from the hospital setting to their homes or other care setting. The Medicare Transitional Care Act, H.R. 6249, directly addresses continuity of care problems by providing incentives to care providers as they move patients from hospitals to their new care setting and by ensuring that appropriate follow-up care is provided during this vulnerable period. These incentives support a number of different peer-reviewed and evidence-based care transition models tailored to the specific needs of the patient. The legislation ensures:

- A comprehensive assessment of the individual prior to the individual's transition from one care facility to another care facility or home.

- The development of a comprehensive, evidenced-based plan of care for the individual developed with the individual, the individual's primary caregiver, and other health team members.

- The development of a comprehensive medications management plan that ensures the safe use of medications and is based on the individual's plan of care.

- Implementation of a plan to facilitate the safe transition of the individual from one level of care, care setting, or provider to another.

- The beneficiary and caregiver are given assistance with coordinating support services (such as medical equipment, meals, home-maker services, assistance with daily activities, shopping, and transportation).

Both the Congressional Budget Office and the Medicare Payment Advisory Commission have recognized that a transitional care benefit would save taxpayer dollars in the Medicare program by limiting patient readmissions. Multiple randomized clinical trials have demonstrated that a transitional care benefit produces significant health outcome improvements, reduces health care costs among chronically ill older adults, and increases patient satisfaction.

This legislation is supported by: Consumers Union, Care Continuum, Hudson Health Plan, National Transitions of Care Consortium, American Society of Health-System Pharmacists, Case Management Society of America, among others.

<Previous Idea


40
WEEKS
Visit the Ideas Index